A JOURNAL FOR NURSES

R.N.

IN.

MARCH 1939

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IN *This* ISSUE

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A JOURNAL R.N. FOR NURSES

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Debits and credits

QUESTIONNAIRE

Dear Editor:

Here comes my special vote of thanks
With a word of warmest praise
For a magazine that satisfies
In so many different ways.
Straight through the year *R.N.* has made
A friendly monthly call;
Its many newsy items—yes,
I've read them one and all!

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So an orchid to your magazine,
It truly is a treat!

Margaret C. Costello, R.N.
Allston, Mass.

[*Our thanks to Miss Costello for this entertaining reply to the December questionnaire, and to the thousand other nurses who also responded.*—THE EDITORS]

"PRACTICAL" STANDARDS

Dear Editor:

May I, a practical nurse, unlicensed, express my opinion? Two of my daughters are graduate nurses, and I see their copies of *R.N.*

The article, "A New Lease on Licensing," and the editorial, "Within the Law," (December issue) were of particular interest to me because they recognize a distinct need for the practical nurse in caring for the convalescent, the chronic or aged, and in helping the young mother. . .

From my observation, I do not believe that the registered nurse and the practical nurse need encroach upon each other's territory, but may be mutually helpful. The doctor on the case usually indicates the type of nurse needed. Frequently, when I have felt that a case required a nurse with more training, I have asked for one and worked with her and under her supervision.

Now, as to licensing the practical nurse—yes, by all means. However, it is "putting the cart before the horse" to require her to be licensed in sections where no institution of training is provided for her. Apparently there are no qualified schools for practical nurses in the State of Washington. I believe each state should have at least one such school, to be affiliated with an accredited hospital. Such an institution would set a standard of service to be expected by the public, would dignify that service, and the practical nurse might then expect a standard remuneration.

Jessie F. Cunningham
Seattle, Wash.

CITIZENSHIP

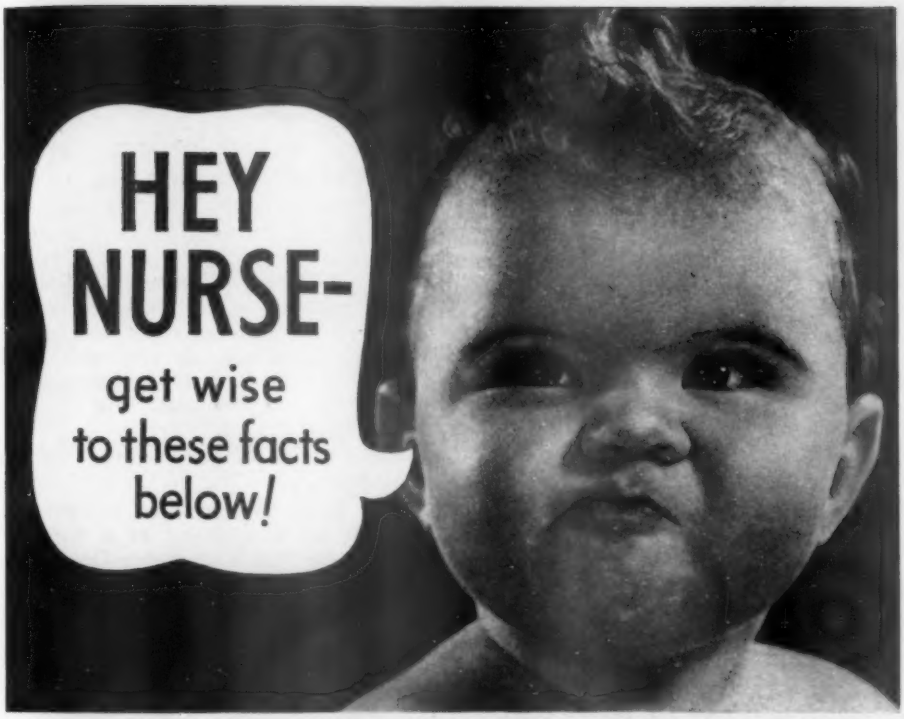
Dear Editor:

Has anyone stopped to consider the unfairness of hospitals employing nurses who are not United States citizens? Many of these nurses are registered, although they have merely declared intentions of citizenship.

I believe training school standards should be set up by the National Government, and that licensing should be through National Board examinations. This would eliminate all the confusion of state reciprocity. What do some of you other nurses think of this?

Frances F. Van Sickle, R.N.
White Plains, N.Y.

[*The new nurse practice act in New York State (where Miss Van Sickle is practicing) requires citizenship, or declaration of intention thereof, prior to registration. Since no law can be retroactive, it does not apply*



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to foreign nurses now registered and practicing in the state. New York calls for completion of citizenship within seven years after declaration of intention.—THE EDITORS]

IT WORKED!

Dear Editor:

Thank you for printing my request for information on how to open a nursing home, ("Calling All Nurses," November). I have enjoyed reading all the replies and have secured some excellent ideas which should help me solve my problem.

Bertha M. Carter, R.N.
Plymouth, Wis.

POOR PRECEDENT

Dear Editor:

The N.Y. *Sun* recently published an item on the appointment of a registered nurse to the New York Police Department. The story said: "She (the nurse) will replace one of the two nurses on the fourth floor at Police Headquarters, either the *practical nurse* now assigned to the surgical ward, or the graduate nurse in the dental division. Both these women are listed as policewomen and draw $3000 annually."

The report has unusual significance for us as a professional group. Apparently this city department recognizes no difference between the registered and practical nurse, and places them in the same salary bracket in positions of similar responsibility. If such an organization hesitates before replacing a practical nurse with a graduate, how can we expect the public to select nursing care intelligently?

R.N., New York, N.Y.

QUITTING

Dear Editor:

A young nurse I know has just given up nursing after graduating creditably from a school of nursing and working for two months at the hospital. When I asked her why this sudden decision, her answer was, "I've had enough of nursing. I want some free time—and a good time."

Why are so many of the younger generation getting this idea and leaving the profession without half trying? Nurses years ago, in spite of 24-hour duty, kept on for the sake of the good they could do.

R.N., Pittsburgh, Pa.

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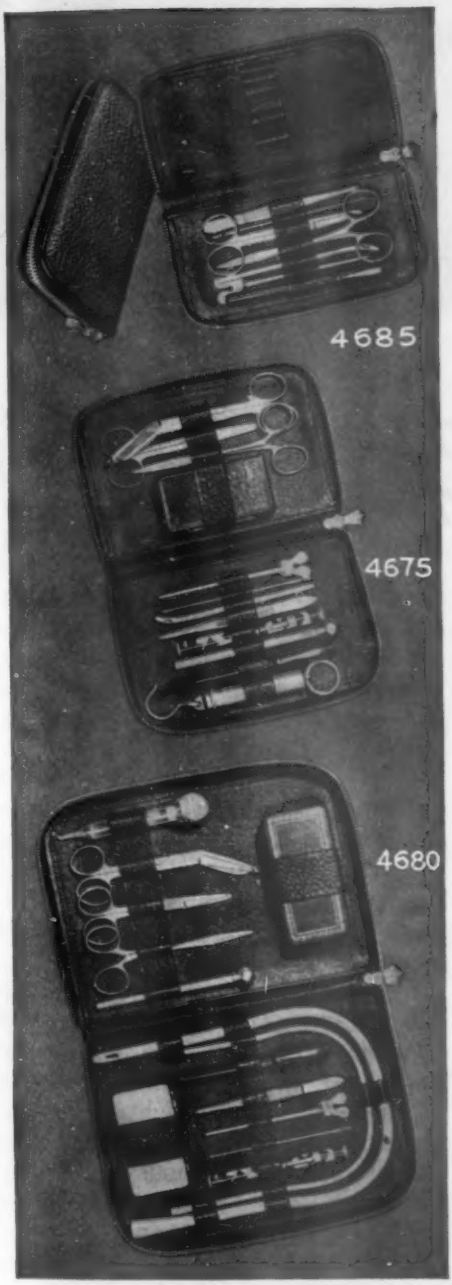

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I survived *Shanghai!*

• ***Last month authorities of the International Settlement and French Concession in Shanghai were dubbed "hostile" by the Japanese-dominated Nanking government. Thereupon began a new reign of terror which, this time, turned its fire toward foreign residents of the belabored area. . .Here are graphic excerpts from the diary of a nurse who lived through another reign of terror—the bombing of Shanghai last August. The author returned to America around the first of the year. She is now on the staff of the Cedars of Lebanon Hospital in Los Angeles.***

Aug. 14—War! War! We are in the thick of it now. Japanese destroyers have already shelled Shanghai University and the Civic Center. Today nearly a thousand people were killed when bombs were dropped in the International Settlement, which we had thought so safe. I had to stand by helplessly and watch the destruction of the Palace and Cathay Hotels. The roads were littered with dead and dying. Our hospital was the receiving station for foreigners. They came pouring in—the wounded piled in rumble seats, some dying before we could treat their injuries. As the hospital had made no emergency arrangements, we were entirely unprepared. Bodies, horribly maimed, were transferred as quickly as possible to different floors, leaving trails of blood behind. Never have I put in fourteen hours of such heartbreaking duty. No care that we could give seemed adequate.

Aug. 17—Every available space in the hospital has been fitted up with cots and stretchers. Food has been cut down. Use of electricity is restricted to early evening. Late night treatments, no matter how urgent, must be done by candle or kerosene lamp light. . . Evacuation of British women and children today, to Hongkong.

Aug. 18—What a scare we had tonight! Eight of us in the nurses' residence were trying to read Wodehouse aloud. Suddenly there was the hissing, screaming sound of a shell hitting its

N.Y. Daily News Photos

Terror, destruction, death! These pictures of last summer's Shanghai bombing show the inescapable horrors of war. They typify the daily tragedy witnessed by the nurse on duty in China.

By BETTY STARK, R.N.

mark. Our lights went out. . .No one moved for a moment. Then we all rushed onto the verandah and discovered that the entire hospital was in utter darkness. Our first thought was that the power house had been bombed. Calls came from the hospital for lamps and candles, and in the excitement of hurrying into our uniforms, we didn't notice that the street lights were on. We never heard what was the real cause of the trouble.

Aug. 19—The French and Danish nationals were evacuated yesterday. Soon there will be no one left but us Americans, and the dead. . .The Yangtze is a mass of battleships and bodies. In Lotein this morning Japanese troops captured a small rickety ambulance and immediately killed its several occupants. The three Chinese nurses who accompanied the patients were made to kneel down, and in this position they were shot. . .There is a sudden scare of dysentery and cholera. Anti-toxin is being shipped with strict orders for compulsory inoculation.

Aug. 21—Everyone was amused by today's paper. The reports said the United States will send troops September first to arrive here five weeks later. How many of us will be left by October?. . .

Aug. 23—Today I ventured downtown to meet a friend at Sincere's department store. Halfway to town, I was stopped. No buses, cars, or rickshas were allowed to go any farther. No one knew why. When I returned to the hospital, I learned that both Sincere's and the Wing On stores had been bombed just a scant half-hour before I was scheduled to be there! Anyone who wanted to leave now would find it next to impossible. The only route out of here is by way of the Whampoo River—the center of the most recent and most destructive attacks.

Aug. 25—I went to sleep last night and woke with the hideous sensation of a hand on my face. I sprang out of bed with a scream, roused my roommate, and, with chattering teeth, told her there must be someone in the room. Terrified, we searched under beds and furniture but found no one. I finally decided that I had felt my own hand which, tucked under my pillow, had gone to sleep and was a heavy, dead thing when it touched my face. I certainly have developed nerves!

Sept. 2—Shanghai itself is fairly quiet and has been for several days. But refugees continue to pour in—begging, looting, dying. Chinese girls can

[*Continued on page* 30]

Dynamite
on the nursing scene

Capping initiates rigid training for the registered nurse (see cut). Should subsidiary nurses receive modified training and be licensed likewise?

By DOROTHY SUTHERLAND

● "Will the licensed practical nurse become a threat to professional nursing?"

For a dramatic example of spontaneous combustion, try popping that question in almost any nursing headquarters office. In states where such licensing is under way, your answer is likely to be a quick and vigorous denial. In other localities your query will probably be met by awkward silence. "That's dynamite," say the executives. "Let's not talk about it just now."

Of course, everyone knows that thousands of practical nurses are already working in all states. Many of these women recognize their own limitations and do not attempt to reach out of the sphere of subsidiary nursing. But hundreds of others have no such conscience. They covet the professional nurse's title, her uniform, her prestige.

Nursing records throughout the country are filled with instances where public health has been endangered by the malpractice of unscrupulous nursing aides. In most cases, the professional group was unable to take steps toward legal prosecution because the offending individuals did not come under its jurisdiction—or under anyone's, for that matter. Yet, that fact seems to draw less fire than the possibility that the practical nurse with a license *may* achieve recognition thereby and consequently compete with the graduate.

Let's look at recent developments in the light of their implications for the future.

In New York State, where (under the new Todd-Feld nurse practice act) 325 practical nurses have been licensed since last July, one nurse official has said: "We believe that licensing for the practical nurse is not the cause, but the *result* of unethical competition by nonprofessional workers in the nursing field. Under our law we will have standards for all nursing activities established and controlled by one logical source—the State Department of Education."

New York's law, so far, has been received with fairly general enthusiasm by practical and registered nurses alike. Practical nurses are willing to meet its rather stringent requirements because it gives them identity according to their *actual capacity* to nurse. Representative graduate nurses believe that this very specification will minimize the possibility of any serious competition.

But on the Pacific Coast, the California State Nurses Association is in the lap of a dilemma. The CSNA stands

Wide World

firmly for nursing by and for registered nurses. Its nursing practice bill, now before the State Legislature, proposes compulsory licensing of graduate nurses, making it "illegal for any others to practice nursing" in California. Hence, the practical nurse would be left out in the cold. (*R.N.—a Journal for Nurses*, December.)

Almost immediately after the appearance of the CSNA bill, a countermeasure was introduced. Sponsored by the American Trained Practical Nurses Association (a California group currently engaged in a membership drive), this measure proposed to set up a Board of Practical Nurse Examiners which would regulate P.N. activities entirely separate from the professional group. Licenses would be provided to legalize practical nursing "under the direction of a licensed physician *or the patient*"—a weakness which would definitely jeopardize safe nursing care, according to the CSNA.

Opposition in the form of a well-integrated publicity campaign was instantly launched by the professional group. Said Mrs. Jennie W. Gardner, legislative chairman, "The practical nursing act was probably not introduced with any hope of securing passage. It was proposed merely to jeopardize the chances of the legitimate (CSNA) nursing practice act, by creating confusion."

The practical nurses, however, through their spokesman Ida B. Pierce, insist that their measure was introduced in self-defense. "The CSNA bill," Mrs. Pierce said, "would legislate practical nurses out of business."

Into the State Nurses Association bill soon went an amendment provid-

ing for "the exemption of practical nurses and office nurses from the provisions of the Act." But the P.N.'s were not satisfied. And to date they are still holding out for their own practice act and the right to examine and direct subsidiary nursing by a board on which "no registered nurse may sit."

Observers close to both sides of the California fracas believe neither bill will pass this year. Many feel that a bill embracing the practical nurse group at the outset would have prevented the impasse. But the real threat of this minor victory for the practical nurses is the effect it may have on similar organizations in other states. Authorities believe the rapid growth of the Practical Nurses Association may encourage their expansion on a national basis. This California group gives every evidence of being well organized, and seems to have the funds necessary to support its activities. A nationwide movement to enact practical nursing acts and to set up independent examining boards would be the next logical step. Soon the chances of professional nursing retaining the reins on standards for all practice would be remote indeed.

Galloway

Professional nurses study anatomy. Should practical nurses have similar instruction?

Last month, nurses in Illinois were startled to find that termites had eaten into their practice act also. From unidentified sources, an amendment reached the House of Representatives and was referred to the Committee on Public Health. It proposes to issue registered nurse licenses to anyone who has "served four years or more as a hospital *corps man, pharmacist,* or nurse in the military service . . . or combination of such occupations."

In a confidential memorandum to its members, the Illinois State Nurses Association asked quick defeat of the measure. "Under this bill," said the memo, "any orderly or female attendant . . . will be eligible to be a registered nurse. Our nurse practice act will be destroyed. Standards of nursing in Illinois will be so lowered that every Illinois nurse will be ineligible to positions in other states."

One committee chairman (who was reluctant to be quoted) said, "This could not have happened had we been armed with a more adequate licensing law. If subsidiary workers held licenses in their own right they would not aspire to the position of the registered nurse."

From Indiana, however, comes a puzzling report. The Delaware-Blackford County Medical Society and the Indiana Employment Service Bureau have joined hands to establish a "registry" to control the activities of practical nurses. According to the medical society the reason is "many cases in the home are unable to afford the services of a registered nurse." Hence, "members of the county society will pass judgment on the ability of the

[*Continued on page* 28]

The story of COD LIVER OIL

How much do you know about the cod liver oil you give daily? In this article, Dr. Scheuer traces its steady rise through two centuries.

By DR. JOSEPH S. SCHEUER

• Cod liver oil, rich in vitamins and the potent factors for restoring health, has become an everyday remedy in the vast field of modern medicinal knowledge. It is given daily to thousands without a thought to the years of development which have made possible its present wide acceptance. Yet its story, like that of most folk remedies, is a fascinating one.

The earliest history of cod liver oil is obscure. It is known, however, that in the 18th Century it was a favorite remedy of Dutch peasants. Probably long before that time it had been taken by North Sea fishermen. Nothing was known of its chemistry, and in view of the crude extraction methods in use then—not to mention the strong fishy odor and unpalatability—its merits must have been great indeed to popularize its use.

Manchester, England, gave birth to a special interest in cod liver oil as an actual medicine. As early as 1789, an essay "On Medicinal Use of Cod Liver Oil" was written there and widely circulated. From then on, records appear of case histories showing its "curative action against rickets," and its value in the treatment of chronic rheumatism. Similar studies were carried on by medical men in France and Germany, and in time the potential curative values of the oil came to be recognized.

Although interest was apparent in the 18th Century, it was not until about 1840 that cod liver oil was introduced into regular medical practice. Professor Bennett of Edinburgh, whose researches were conducted over a period of years, showed it to be of special value in stimulating epithelial growth and mucosa. Other investigators reported its value in the upper respiratory tract. It was soon generally accepted as an aid in the treatment of tuberculosis. Chemists studied its components and, as each factor was isolated, that factor was immediately assumed to be the active principle of the oil—only to be disproved by further study.

During all these years when scientists were becoming, perhaps, just a little excited about the possibilities of cod liver oil, the demand for it was constantly growing. Year in and year out, thousands of fishermen in the stormy waters of the North Atlantic and the North Sea, were bringing in tremendous loads of codfish.

Each day's haul represented some new hazard overcome. As a result of fishing from small open dories in high

seas, heavy fog, and often bitter cold weather, hundreds of men lost their lives every season. Larger vessels are used today; but in spite of radio equipment and other modern safeguards, most of the old dangers remain.

Originally, only the flesh of the fish was sold. The catch was brought in and dumped on the quays, and the fishermen were usually given the livers. No one else wanted them. For generations, apparently, they had been extracting the oil for external application. Sometimes, when they stayed at sea for weeks at a stretch, they would drink it to keep up their strength. They were unaware of its real chemistry but instinctively turned to it as a source of energy. Cod liver oil is still an important part of every trawler's first-aid supply.

As demand for the oil increased, it was extracted crudely and sold commercially. Sometimes the fish livers lay in baskets on the docks for a day or two before the oil was removed.

Modern methods are quite different. As soon as the fish are caught, the livers are removed and put into steam boilers on shipboard.

Samples of this crude oil are taken to laboratories and tested on chickens and rats to determine the vitamin potency. Oil for medicinal purposes is then refined until it is pale yellow in color and little odor or taste remains. It is packed in bottles and is sometimes wrapped in cellulose paper to protect the oil from the deteriorating effects of light.

Because of the unpleasant taste of the original oil, many experiments were carried out to find something that would mix with it and disguise its flavor. None of these attempts was entirely satisfactory. In 1870, however, in a little chemist shop on lower Broadway, New York, Alfred B. Scott and Samuel W. Bowne succeeded in making a stable emulsion of cod liver oil that was easy to take and readily assimilated. These men took advantage of a natural means of insuring fat digestion. They emulsified the fats in the oil, simulating the process of emulsification which takes place in milk.

Tests recently completed indicate that the emulsion can be digested approximately five times faster than non-emulsified oil. The findings suggest that oil in emulsion speeds up fat oxidation. Thus, the therapeutic qualities of the oil may be more readily absorbed by the system and a quicker metabolic reaction produced.

For years cod liver oil was used mainly as a tonic. Then in 1914 Osborn and Mendel showed it to be rich in fat soluble vitamins A and D. Again authorities attempted to explain its value on the basis of vitamin content. In 1922 Kirschner's studies led him to the belief that the effectiveness of the oil arose not only from its vitamins but also from the presence of unsaturated fatty acids. Other scientists have paid tribute to the phosphorous and iodine content, and to the organic bases found in the oil.

Today cod liver oil research continues, keeping pace with steadily increasing public consumption. Various forms and combinations have been developed to increase its effectiveness and palatability. While all this highly scientific work progresses, dramatic enough in itself, the drama of deep sea fishing also continues. Off the coasts of Norway, Newfoundland, Greenland, and other northern shores, fishermen still battle storms and fog to bring in their precious loads of this health-giving oil.

Nutrition Briefs

• Jiggs has always preferred cabbage. But there are some people with whom it is taboo because of the digestive distress it causes. To test cabbage as a cause of discomfort, 20 healthy individuals, who had previously suffered from eating cabbage, were studied during two 5-day periods. Each ate cabbage or cauliflower daily. Other foods served

were prepared with a minimum of fat and seasoning.

Cabbage and cauliflower cooked for an hour and a half proved to be the worst offenders, creating digestive discomfort among 70 to 75 per cent of the group. Only slightly less distressing were raw cauliflower, cabbage cooked 45 minutes, coarsely shredded raw cabbage, cauliflower cooked 45 minutes, and finely shredded raw cabbage. Cabbage cooked 12 minutes and cauliflower 15 minutes were the least troublesome and affected only 5 per cent.

Sulphur compounds cause the strong flavor and odor of these vegetables and increase with prolonged cooking. It is interesting that the period of cooking which produces the mildest flavor also results in the least gastric disturbance.—*Hughes, O. and Campbell, L.: The Influence of Preparation on the Disturbing Effects of Cabbage and Cauliflower. J. Amer. Dietetic Ass'n., Jan. 1939.*

• Premature infants must be handled by nurses who are experts in feeding. Overfeeding—too rapid administration or too rapid increase in the day's food—must be avoided as carefully as underfeeding.

Increases in food are based on weight of the infant and its food tolerance. When the baby is under 1000 grams, the increase is never more than 1 c.c. Irrespective of size, the increase is gradual and never more than 3 c.c.

Breast milk is the best food—boiled where there is any doubt about the source. When a substitute is necessary, there should be low fat content and a fine curd. Fresh milk should be boiled for five minutes. To counteract loss of vitamin C through boiling, orange juice should be started by the third week, as well as an anti-rachitic. Egg yolk, iron, or a liver preparation should be included by the fourth week.

"Proper food, good nursing and much good judgment are most essential in the care of these infants."—*Hess, J. H.: The Premature Infant—Early General and Feeding Care. Ill. Med. J., Dec. 1938.*

• To those who have barely enough will power to stay slim by cutting out the extra this or that, comes the inspiring report of a housewife who, by faithfully following doctor's orders, lost 239 pounds! In 20 months she tumbled from

a weight of 395 to 156, at which time she was in excellent health and spirits.

Physical examination with complete laboratory tests at the beginning of the treatment indicated simple obesity, due

[*Continued on page* 42]

Keep your top knot *Shining*

By KAY MARCH

• On duty or off, your hair should form an attractive frame for your face. If your mirror reveals instead that your hair is dull, lifeless, and uninteresting, try to budget your time so that you can spend a few minutes a day on a simple beauty routine that will give it new life.

First of all, hair needs cleansing. Not only that important weekly shampoo, but daily cleansing. You've noticed how much soil your face collects during an average day. An equal amount of dust and soot settles on the hair and mars its loveliness. If you have a towel handy while you brush, and keep wiping the bristles every so often, you'll be amazed at the soil it removes. Correct brushing, too, will give you a wonderful feeling of exhilaration as you pull and tug at those hair roots, thus exercising flabby scalp muscles.

Be sure your brush has firm, resilient bristles that will penetrate right down to the scalp. Begin at the nape of the neck. Place your brush on its side and give it a half-twist to imbed the bristles firmly in the hair. Then, with a jerky, vibrating movement, brush up and out to the very tip ends of the hair strand. If you don't feel the tug way down to the hair roots, you've slipped up somewhere. Try again until you do feel it.

Part the hair in strands and brush each one until you've covered the entire back of your head. Then work all around the faceline to loosen any particles of dust or makeup that may be lodged there. Next, concentrate on the top of the head. Part the hair there in sections just as you did the back. Take a strand at a time. Brush each one individually until you've completed the entire head. By this time your scalp will be warm. It will tingle from its brisk cleansing massage. Lastly, whisk the brush quickly through your hair in long, swift strokes.

Even one good brushing is a tonic for your hair. It will cause it to gleam with highlights. But aside from hair beauty, brushing is the best possible natural aid to hair health. The friction of the bristles brings a flow of blood to the hair roots. With it comes the nourishment upon which hair grows and thrives. Then, too, cleansing the scalp of scaly waste material allows the pores to breathe. It stimulates the flow of that beautifying oil which is nature's lubrication. Brushing distributes this oil evenly over the hair strands and polishes them until they gleam with lustrous beauty. Daily hair brushing should be as automatic as tooth brushing.

If your hair is dry and brittle, or if you have a dandruff condition, preface your shampoo with a hot oil treatment. Here's the technique:

First brush as advised. Then divide the hair in four sections, one part down the middle from back to front, one from side to side across the head. Divide each of these sections into four parts and with a small cotton pad apply warm

oil at the part, rubbing it in well. Change the pads as they become soiled. Then run a pad down the length of each strand till it is saturated to the tips.

The best time to give your hair a thorough brushing and hot oil treatment is the night before you shampoo it. Wrap your head in a warm towel and go to bed. This will give the oil plenty of time to soak in and to do its work thoroughly. If you aren't able to wait till morning for your shampoo, wrap a turkish towel wrung out in hot water around your head after the oil treatment. Keep the towel on until it cools; then apply another hot towel. This steaming makes the oil marvelously penetrating. After about ten minutes of steaming, go ahead with your shampoo. Give your head four soapings instead of the usual three to remove most of the oil from your hair. Otherwise it may be flat and unmanageable for a few days.

If you're planning to get a permanent wave, remember to give yourself this hot oil treatment both before and after your wave. The permanent will "take" better if your hair is in good condition. The process, as you know, is rather drying.

Now to bring out natural highlights. The secret lies in the use of a rinse after shampooing. Blondes will put their best faith in a quarter cup of strained lemon juice to a bowl of warm water. Brunettes will use a like quantity of white vinegar. There's nothing new about either, but then, there are a few ancient beauty secrets which still can better most competition.

Once every six weeks or so, go to a beauty salon for a massage and shampoo. Although your own personal attention is the basis for hair health and beauty, there is something to be said for the salon treatment too. A trained beauty operator can give your head a thorough massage and a vigorous sudsing which will point up your own efforts. You'll find her treatment relaxing and refreshing at the end of a tiresome day in the hospital. And, incidentally, she can probably give you a few tips which will make your home care more effective.

[R.N. *will send you a list of hair tonics, shampoos, and other treatment accessories. Just enclose a stamped, addressed envelope with your request.*—THE EDITORS]

Photo courtesy F. W. Fitch Co.

"That feels good!" Treat yourself occasionally to a brisk professional massage and shampoo.

Registry service

—AN EDITORIAL

• Within the past year, key nursing bureaus in various parts of the country have added a unique feature to their long line of professional services. They are offering "refresher" courses in nursing procedures to the private duty nurses on their lists.

Two important results are thus obtained: First, nurses who have become hazy on procedures they have not used for some time, enjoy an opportunity to brush up, to keep posted on modern methods. Second, profits from successful business operations are being directed back into new services for registrants.

We hail the purpose of this venture, and the success of the program to date, as a decidedly forward step. To the women who originated the idea, goes the credit for assuming an important responsibility: the responsibility of helping other nurses keep prepared for adequate nursing posts.

Why, however, should this task have been left to the registries? Why has it not been assumed—long ere this—by organized nursing itself?

It would seem highly logical for every local nursing group to sponsor a series of refresher courses for all pri-

vate duty nurses who wish to attend. Not an occasional institute, not a round-table discussion once a year, but a carefully balanced educational program. Even one such meeting a month should be of great value, and not excessively difficult to provide.

We believe the primary function of a good registry is to place qualified nurses in suitable nursing posts. This in itself is a tremendous task. It involves not only a thorough knowledge of the employment field but also a thorough understanding of the individual applicant, her personality, her problems.

Registries that render a careful placement service employ trained personnel specialists. Their job embraces far more than the mechanics of filling vacancies with nurses who want work. They must offer professional counsel, vocational guidance. They must provide the means by which each applicant may find her own particular niche within the nursing field. But they should not be required to *teach* the applicant how to become an up-to-date nurse.

Let educational groups retain the burden of providing instruction. Let employment groups concentrate on finding or creating jobs. Any effort by either group to undertake the function of the other is bound to distract each from its basic purpose. The resulting confusion will serve, only too pointedly, to encourage more and more nurses to ask: "What is my profession doing for *me*?"

"On the third day the 'close friends' started to move in..."

By ROXANN

Greeks bearing gifts

• Once upon a time I had an ideal patient. He didn't have a visitor all the while he was ill...

Generally speaking, there are two classifications of visitors: perfect ones and the ninety-nine other varieties. The ideal caller-on-the-sick comes in quietly, stays for ten minutes or so of really cheerful conversation (not the sweetness-and-light stuff that makes most patients squirm). Then she goes her way without urging. If she brings gifts they are of the non-edible, not-too-odorous variety.

"...acknowledging a life supply of bed jackets."

But the ninety-nine other types—

I remember especially the case of Mrs. Van Froth, who lived in a country house only two rooms smaller than the Palace of Versailles. Mrs. Van Froth had a cardiac condition and the doctor ordered a complete rest for a few weeks. I was called in to make sure that the patient would stay in bed and *relax.*

For the first day the house was as still as a grave. But on the second day the phone rang, and rang, and rang. I did a Marathon answering it. *Why,* they asked, couldn't they talk to dear Effie for just a *minute?* They were the *closest* of friends...

On the third day the "close friends" started to move in. They intended to stay "just a bitsy minute." But, at the end of a half hour, I'd find myself prying them out with a crowbar. My patient was cheered with gay little tales about Aunt Matilda who popped off "just like that" after a similar cardiac bout. And before her guests left they would loudly beg me not to let

the dear girl overdo. "It would be so awful to lose her, y'know." (!)

After about a week of this, Mrs. Van Froth took things into her own hands. One day I walked into the room to find her just slipping into her mink coat. "Why, Mrs. Van Froth," I said, "you mustn't—"

"Oh, mustn't I?" she answered grimly. "You just tell the doctor that relaxing in bed is too much of a strain. I haven't the energy for it. I'm going to a board meeting, a luncheon, and I'll be back in time to dress for dinner. It'll be a nice rest!"

I think she was one of the many patients who recover in spite of their well-meaning friends. . .

It's a wonder to me that some of the youngsters in the children's wards, for instance, ever survive the attentions of their doting parents. Visiting hours inevitably start just when the nurses have the ward calmed down. In rush Daddy and Mommy then to coo and weep over Junior; and before you can say Jack Robinson they've plied him with the cream puffs, bags of chocolate, hammers and mirrors—plus anything else they think will amuse him. Quick as a flash Junior licks the paint off the red and green top that Aunty gave him, and comes down with a first-class tummyache. (Oh for a ward where gift-inspection rules are enforced!)

Just when the tempest has reached its height, the warning bell rings to announce that visiting hours are nearly over. The timid souls and the law-abiding visitors march away meekly. The last bell rings five minutes later, but the hard-of-hearing contingent stays blandly by the bedside of the young patient. Finally a nurse announces firmly and loudly, "Visiting hours are over." The stragglers look up, wide-eyed as Shirley Temple: "Why, we didn't hear any bell."

But after they've all gone—that's when the fun really begins! There's a virtual symphony of wails and howls. Four-year-old Jimmy tries to pull off his mastoid dressing. Three-year-old Ann sobs herself into hiccoughs. Johnny shrieks that his dog must be brought to the hospital. And so on, far into the night.

Visitors in the communicable disease division are probably the most woolly-headed of the tribe. You take them aside, drape them in clean, unironed gowns, and spend ten minutes explaining just why the patient with diphtheria or scarlet fever must not be touched. Yet the minute you turn your back, what happens? Mother and little Margie are in each other's arms, with Mother scooping up a nice collection of bacteria to take home to the seven other members of the family.

The gift-bearers, too, certainly complicate life for both patients and nurses. Pity the poor post-operative, whose friends bring him everything from French pastry to the more odoriferous

[*Continued on page 32*]

"...with Mother scooping up a nice collection of bacteria..."

Quick facts about Sepsis and Asepsis

A CONCISE REVIEW OF CURRENT THERAPY AND NURSING CARE*

• **Bacteriology and nursing.**—The relationship between the science of bacteriology and nursing is an intimate one. The nurse, who aids in the treatment of many diseases due to bacterial invasion, must be thoroughly familiar with the fundamentals of bacteriology and with methods of preventing the occurrence or spread of infection.

The presence of living organisms invisible to the naked human eye was established by Leeuwenhoek. In 1683, he described "tiny animals" which he had observed by means of a microscope of his own invention. In the years that followed, many investigators, including Pasteur, Lister, and Koch, laid down the fundamentals of bacteriology.

Bacteria are unicellular organisms and represent the lowest, simplest form of plant life. They are rod-shaped (bacillus), spherical (coccus), spiral (spirillum), whip-shaped (vibrion) and club-shaped (when containing spores at one end—clostridium). In addition to their differentiation on the basis of shape, micro-organisms are also classified as aerobic and anaerobic, depending on whether they can live in the presence of oxygen. Another classification is based on their staining qualities—gram positive and gram negative.

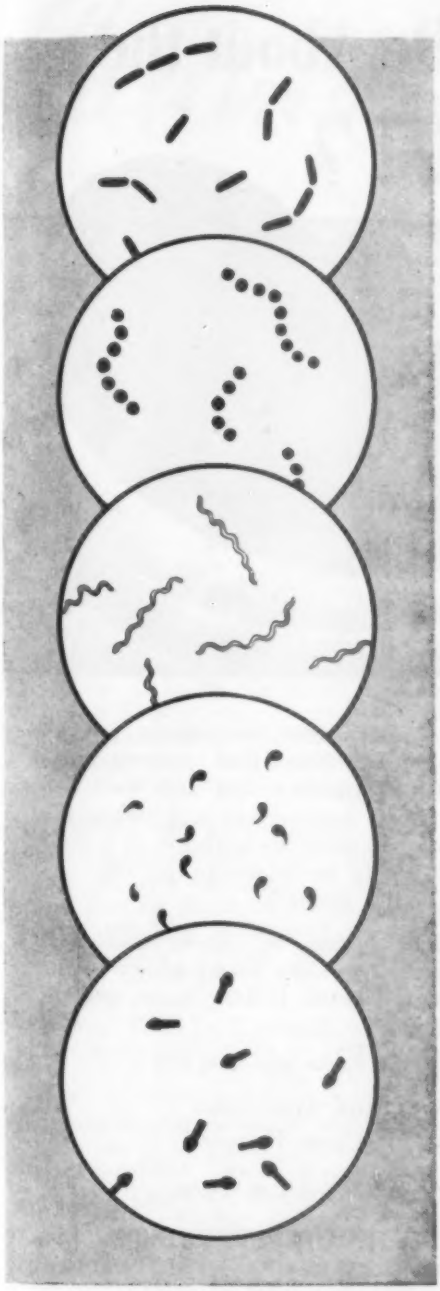
Their size is minute, necessitating a powerful microscope for their study. The average bacillus measures 2 microns (1 micron equals 1/1000 millimeter or about 1/25000 inch) in length and about ½ micron in diameter. The cocci (spherical forms) measure about 1 micron in diameter. The spirilla are about 1 to 2 microns in diameter and 10 to 40 microns in length.

Different species vary in size. The filtrable viruses are too small to be seen, and pass through the pores of a porcelain filter, which readily stops the visible bacteria. These invisible living objects can be cultured and destroyed. They produce disease when introduced into susceptible animals.

Bacteria are universal in their distribution. They are found in the air and upon virtually every object that has shape or form. Indeed, one may expect to encounter living bacteria of some kind everywhere except where conditions are not conducive to their reproduction. Hence, in aseptic technique, every object not recently sterilized is considered infested with micro-organisms.

With few exceptions, bacteria, especially those which are pathogenic for man, grow best at 37° C. (body temperature). Optimum environmental con-

*This is the ninth of a series on frequently encountered diseases. Inquiries will be answered promptly by the medical and nursing members of *R.N.*'s staff who prepared the material.



The five basic types of bacteria. Top to bottom: rod-shaped, spherical, spiral, whip-shaped, and club-shaped.

ditions—pH., type of culture medium, moisture, presence or absence of air—are essential for most rapid growth, and vary from one species to another.

Bacteria multiply by simple division. The cell, attaining full growth, divides, forming two cells which quickly grow and divide again. Cell division may be repeated every hour. This explains the rapid development of bacterial cultures. Multiplication of bacilli usually takes place by division at right angles to the long axis. With cocci, if division takes place in one plane, a chain is formed (streptococci). If division occurs in two planes, flat masses are produced (staphylococci); if along three planes, grapelike masses or packets (sarcinae) result. Streptobacilli, diplococci, and diplobacilli have been described.

While most bacteria require oxygen for growth, a special group, the anaerobes, live only in the absence of air. The bacilli of tetanus and gas gangrene fall into this category. Hence, in the treatment of wounds thought to be contaminated with either of these microorganisms, wide incision or exposure to air is an effective means of inhibiting bacterial growth.

Under adverse conditions, some bacteria may assume the spore state. Sporulation is analogous to hibernation. In this form, bacteria are highly resistant to heat and chemical influences and may survive for many months or years. When the spore is again exposed to conditions favorable for growth, it reverts to the vegetative state. Fortunately, not many species are spore formers, although many anaerobes do belong to this group.

Pathogenicity.—In the production of any infectious state, three factors govern the severity of the resulting

[*Continued on page* 36]

What Physicians Do About the JITTERY GUT?

For a reliable antispasmodic to relieve gastro-intestinal spasms, physicians find non-narcotic TRASENTIN,* "Ciba" quick-acting and well tolerated. It relieves *both* neurogenic and myogenic spasms of many smooth muscles without as a rule manifesting toxic effects or undesirable side actions in full therapeutic doses.**

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**Einhorn, M., AM. JL. DIG. DIS., April, 1938

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Calling all nurses

Is there someone in the profession you'd like to get in touch with? Already, this department has brought together scores of old friends! If you've lost track of a classmate, or want to find a co-worker from early nursing days, address a notice to the "Calling all nurses" editor. Each notice should not be longer than 100 words. You may sign your message with initials or a nickname, if you wish. But be sure to send along your full name and address so that replies may be forwarded to you. There is no charge for this service to registered nurses.

EDITH DEAN: Are you still in California? I lost your address and am very anxious to hear from you. Please write. Mary Raiber, 379 St. Lawrence Ave., Buffalo, N.Y.

SUSANNE TREINLER: I hope you will see my "call" and send along your address right away. (I should like to get in touch with Miss Treinler, my former pediatrics supervisor, and would appreciate any information supplied.) Margaret King Johnson, 28½ Cottage Grove, Wallace, Idaho.

CATHERINE "MAE" JOHNSON: M.I.C. and I are anxiously waiting word from you. I heard you were stationed in or near Galveston, Tex. but that's not definite enough for the postoffice! How about a letter? Kathleen "Land" Moran, 6230 Oakland Ave., St. Louis, Mo.

FRANCES FEELY: I haven't forgotten how nice you were to me in 1933 at the Gordon Hotel in Washington, D.C. When I last heard from you in New York I thought that would be your permanent address. But I've lost you again. (Miss Feely is a Johns Hopkins alumna.) Harriet Metz, 315 N. Maple Ave., Oak Park, Ill.

GWENDOLYN DARCY NEWHOOK, DOROTHY PELLEY, FLORENCE CLARK: What's happened to my favorite classmates, class of '30, Bellevue Hospital? Haven't the slightest notion where you three are. I left New York in 1932 and feel stranded with no news. Evelyn Cushman (Mrs. Burt Davenport), 86 Lamb St., Cumberland Mills, Me.

MARY O'CONNOR: Does anyone know how I may locate this nurse? I believe she was employed by a private hospital in Philadelphia, and that she has a sister living in the East 60's in New York. She made a short stay in New York around Thanksgiving last year. Edith Lynch, 137 Clarence Rd., Scarsdale, N.Y.

DISABLED WORLD WAR NURSES: Join the nurses' chapter of Disabled American Veterans. We need you and you need the comradeship of your own buddies. Regardless of where you live, we welcome you. Communicate with the Commander, 539 Hawkins Ave., Braddock, Pa.

MERCY HOSPITAL ALUMNAE: *R.N.—A Journal for Nurses* has been asked to request all graduate nurses of Mercy Hospital, Johnstown, Pa. to notify the director of nurses as to their location as soon as possible.

MILLA ROD: Where are you? Dot Hans Bruce and Miss Fowler would like to know. Miss Fowler is ill and wants so much to hear from you. (Miss Rod is a graduate of C.T.S., Denver, Colo., class of 1907.) Anna Hansen Burns, Route 11, Oakland, Neb.

MISSES O'NEILL, WALP, and JOHNS: These are all nurses from the Pittsburgh unit who were at Base Hospital 27 at Angers, France, in 1918. I should be very glad to hear from them. P. B. Brennan, 728A North Taylor Ave., St. Louis, Mo.

Dynamite

[*Continued from page* 14]

practical nurses enrolled and only those whose work is found satisfactory will be permitted on the registry."

To insure suitable training and background for these practical nurses, a program of demonstrations and lectures on nursing procedures is being arranged by members of the *medical society*.

Although the plan was written up fully in the January *Journal of the Indiana State Medical Association*, there was no indication that the State Nurses Association had either volunteered or been asked to cooperate.

Here again the danger seems to lie in the growth of practical nursing without the guidance of professional nursing education.

Chief objection voiced by graduate nurses to the possibility of letting practical nurses shift for themselves seems to lie in the haphazard and inconsistent standards of the non-professional group. Only recently have any attempts been made to establish minimum educational requirements. And, in many instances, what little training the practical nurse had was secured from correspondence schools or other "short courses."

Advocates of licensing for "all who nurse for hire" have strong opinions in this respect. They believe everyone who tends the sick—aide or professional nurse—should meet standards of education and practice established by a thoroughly reliable source. They believe further that professional nurses are in a key position to help formulate standards for all nursing services—subsidiary as well as graduate. It is not enough, they contend, to attempt to license the practical nurse. An educational plan, based on present-day public health needs, must also be provided.

New York's experience in setting up such a program, even at this early date, is a good example of the results which may be obtained. Through the cooperation of the New York State Nurses Association, the State Department of Education, and the Ballard School of the Y.W.C.A., a ten-months' course for practical nurses has been developed. Currently, this is functioning only in New York City where the school has had the assistance of the city Department of Hospitals. But similar courses will soon get under way.

The course is being conducted by registered nurses and has so far enrolled 120 students of practical nursing. It comprises three months of preparation in theory and practice, six months of hospital ward experience, and one month of final instruction at the school. At the conclusion of the course the students receive certificates and are eligible for

The convalescent must often abstain from the usual foods and physical activity which help stimulate peristalsis.

In such cases, Saráka aids in toning and strengthening the intestinal musculature which has become flabby from inactivity. Bland, easily-gliding, lubricating ***bulk*** (provided by bassorin) mixes intimately with the feces—softening and smoothing them. Frangula, subjected to a special process, is incorporated in an amount sufficient to induce adequate ***motility*** by its gentle tonic action. This combination of

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licensing as practical nurses under the laws of the state. According to state nursing standards, they will be equipped to give safe practical nursing care.

"We are making an earnest effort," said the director of the course, "to interpret hospital situations so that the practical nurse may develop initiative—but not aggressiveness. We want to prepare her to exhibit understanding and tolerance toward the professional graduate. The graduate, however, must exert the same sympathy if the two types of workers are to function happily together. She must assume her responsibility for the subsidiary nurse."

Nurse leaders in various sections of the country report that increasing strength among practical nurse organizations may well touch off the fuse that leads to hidden explosives in the licensing situation. In any event, all are agreed that only a frank discussion of the problem by organized nursing will help clear the air at this critical time.

I survived Shanghai

[*Continued from page* 11]

be seen any time of day following the soldiers and shouting out their offers. It is degrading and horrible—the most nauseating scene yet. There is little semblance of law and order left in this one-time orderly city.

Sept. 3—Local groups have finally set up a few refugee camps. Some are in theatres and night clubs, with the bars fixed up as dispensaries and rest-rooms equipped for emergency surgical work. Even dance hostesses have pitched in and are helping to care for the sick. . .Cholera is beginning to spread. A number of cases have been reported in the Settlement. We've had a few suspects at the hospital, but shipped them off to Isolation as soon as we received a positive culture. Conditions at the Isolation Hospital are appalling. Several of its nurses are patients here with nervous breakdowns and various disorders resulting from overwork. Its wards are so crowded that some of the patients are lying on mattress pads only; others are sprawled three or four on one rickety cot. No one has adequate covering.

Sept. 19—Just when we thought everything had let up a little, Shanghai suffered its severest bombing. It was a beautiful moonlit night, and we were getting ready to go dancing (for the first time since the war began). Enemy planes were sighted and soon the duel between bombers and anti-craft was on. The serpent-like trail of fire from the shells made a heroic pattern in the

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sky. But the aftermath!—Showers of sparks came down, leaving whole blocks on fire. The destruction was terrific. . .In spite of it all, we did go dancing, and the music drowned out the sound of the bombing.

Oct. 1—Heavy bombardment at the North Station this morning. The vibration almost threw me out of bed. Later in the day everything became calm again, though ominously so. Oh well, one day of peace and quiet doesn't mean a thing—I have just to pick up the paper. . .

Greeks bearing gifts

[*Continued from page* 23]

brands of cheese and salami. Or the diabetic whose room looks like the Woman's Exchange with its jams and jellies and cookies—which he later donates to the maids and orderlies. And the tuberculosis patient who receives an electric clock to cheer his long convalescence. Or the seven-day patient who spends weeks acknowledging a life supply of bed jackets.

Over and over again there is the adoring wife who barges in with a half pint of ice cream. She stops the show until she can get a spoon and plate and permission to feed the delicacy to her husband—who has just had some with his latest meal. Then little Honeybun, completely pleased with herself, flits around talking baby talk and handing out the latest bridge-table gossip. After one of these sessions it takes almost a lethal dose of sedative to quiet the patient so that he can sleep.

Maybe some hospital will some day inaugurate a course in "How to Visit the Sick." If that moment ever comes, I'm going to volunteer to play teacher!

Comparative Effects of Alka-Seltzer and of Aspirin Taken After Meals on the Empty ing Time of Stomach

CROSS-SECTION TABULATION OF EXPERIMENTAL RESULTS

SUBJECT	GRUEL MEAL	GRUEL MEAL PLUS FOUR ASPIRIN TABLETS	GRUEL MEAL PLUS FOUR ALKA-SELTZER TABLETS
	MINUTES	*MINUTES*	*MINUTES*
E.B.	90	90	60
V.B.	90	120	75
C.K.	75	120	75
E.P.	75	90	90
T.C.	105	150	90
M.C.	90	135	75
AVERAGE	88	118	78

AN EXTENSIVE series of laboratory and clinical experiments were conducted under controlled conditions to determine the value of Alka-Seltzer as an agent for the relief of minor ailments.

One phase of these experiments is depicted in the above cross-section tabulation.

A more detailed account of these interesting and informative studies is being prepared in the form of a comprehensive, illustrated booklet which will be distributed with our compliments to interested physicians.

The conclusions of the investigators in regard to the above phase of their studies are as follows:

CONCLUSIONS

1. The average emptying time of the stomach after consumption of a test meal followed by Alka-Seltzer was 12 per cent less than the average emptying time after the meal alone.

2. The average emptying time of the stomach after consumption of the test meal followed by aspirin was 34 per cent greater than the average time for the meal alone, and 51 per cent greater than the average time for the meal followed by Alka-Seltzer.

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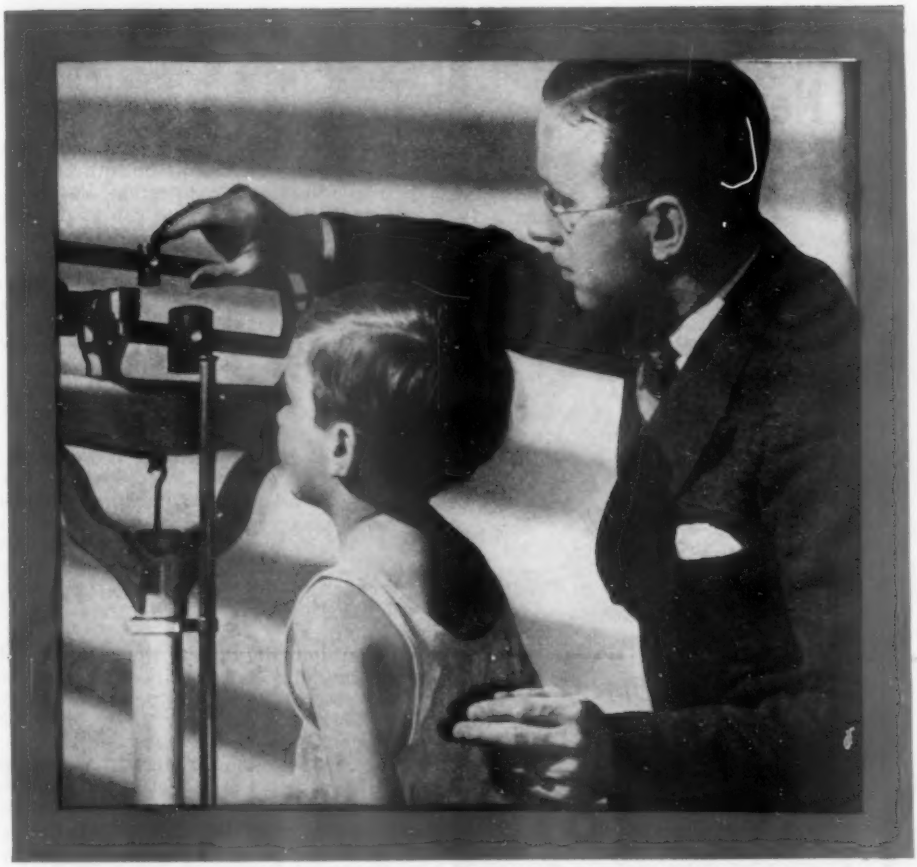

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Sepsis and asepsis

[*Continued from page* 25]

condition: (1) the resistance of the host; (2) the virulence of the organism; and (3) the number of invading organisms.

The human body can act as host to many micro-organisms and may be severely damaged or even killed by infection. Pathogenic organisms are those which can successfully invade human tissue. But the presence of pathogenic bacteria in or on the body does not necessarily lead to disease. For example, the mouth of a healthy person may contain as many as 40 different species of virulent bacteria, including the pneumococcus and the diphtheria bacillus. Usually no infection is produced because the healthy individual is able to prevent these organisms from gaining a foothold.

During certain conditions, however, disease results. Exposure to cold, thirst, hunger, fatigue, alcoholic intoxication, and malnutrition decrease bodily resistance and favor the development of infection. The age of the individual is an important factor in immunity, and it accounts for certain "childhood diseases" which rarely occur in the adult.

Racial immunity is a well-defined phenomenon. The more primitive races are highly susceptible to smallpox and tuberculosis, while it is said that the Hebrew race has become resistant to tuberculosis.

Persons who harbor certain pathogenic bacteria without ill effect are known as carriers. Organisms present in their throats and mouths may be transmitted through the medium of a drinking glass to another person not so resistant, and a virulent infection may be produced in the latter.

The skin contains many streptococci and staphylococci on its surface. No infection is set up because the integument is an effective barrier. However, should the skin be broken or its resistance be lowered by injury, the micro-organisms gain entry into the deeper structures, and infection quickly follows.

It is important to remember, therefore, that pathogenic bacteria are harbored on and in our persons at all times and are ready to gain a foothold whenever we can no longer ward them off. By maintaining ourselves in good condition, we can, within limits, avoid illness.

The virulence of the invading bacteria is an important factor in determining the severity of the disease produced. All physicians have observed that the severity of measles or influenza varies from season to season. The factors which determine this difference are unknown. The pneumococci, streptococci, and staphylococci show year-

ly or seasonal variations in virulence. That virulence is not constant for any given strain or species may be demonstrated in the laboratory. Here it is possible to produce "attenuated" strains of many species which may be extremely low in virulence or entirely avirulent.

The number of invading micro-organisms plays an important rôle. The implantation of a small number of bacteria may lead to no infection; large numbers may set up a serious involvement. The ability to cope with bacterial infestation is determined usually by the condition of the host. Bacteria may gain access to the subcutaneous tissues via the sebaceous and sweat glands. Ordinarily infection does not ensue. But if a large number of organisms are present, and if the resistance powers of the skin are impaired, a furuncle or a carbuncle may form.

Effects of bacterial invasion.—In general, bacteria exert their deleterious influence on the human organism in one of two ways: (1) through the elaboration of a toxin; (2) by rapid multiplication in the tissues and blood stream.

In the toxemias, the invading bacteria grow in a localized area, but elaborate and release a toxin which is carried to all parts of the body by the circulation. In tetanus (a toxemia), the focus may be an insignificant scratch, yet sufficient toxin is produced to affect the central nervous system. In diphtheria, both phases occur; the multiplying organisms produce the typical diphtheritic membrane, a prominent feature of the disease, in addition to the systemic intoxication. Bacillary dysentery is another common toxemia; the organisms develop in the intestines, setting up diarrhea and disseminating their specific toxin.

When pathogenic micro-organisms are implanted in the tissues, as by a laceration, the wound is said to be contaminated rather than infected. Immediate application of a potent antiseptic will usually destroy the bacteria, and healing without infection follows. However, if not so treated, the wound reacts differently. The bacteria, exposed to favorable conditions, multiply rapidly and invade the surrounding tissues. In an attempt to control the infection, polymorphonuclear leukocytes (phagocytes) are brought to the wound and destroy the bacteria by engulfing them. Tissue fluids accumulate, and drainage appears in the form of pus. This purulent discharge is highly infectious, since it contains, in addition to dead leukocytes, dead bacteria, and liquefied necrotic tissue, innumerable living bacteria. Hence the necessity of destroying or thoroughly sterilizing anything that has been contaminated by contact with pus.

Since the bacteria, in the course of proliferation, invade the deeper structures surrounding the original wound, the application of antiseptics to an infection is entirely futile, inasmuch as no more than surface sterilization can be attained. Eradication of infection comes about largely through disposal of the invading bacteria by drainage and by the action of the phagocytes. The application of hot moist dressings increases local blood supply, and aids in bringing defense elements to the infected site. Specific chemotherapeutic measures such as sulfanilamide, or the administration of specific antitoxins, aid further in overcoming infection.

If the infection continues to spread, micro-organisms may enter the bloodstream and continue to multiply, creating a septicemia. If distant organs or tissues become infected and new foci are established, a condition termed pyemia is said to exist. Septicemia is not uncommon in lobar pneumonia, typhoid fever, and scarlet fever. It is the rule in the advanced stages of bacterial endocarditis, where the infection of the heart valves sends showers of streptococci into the bloodstream. Thus the prevalence of metastatic infectious foci in scarlet fever and pneumonia is understandable.

[*Turn the page*]

Many common diseases result from septicemia or pyemia. Osteomyelitis is frequently produced by micro-organisms that enter the bloodstream from a distant infectious process and lodge in a bone. Bacterial endocarditis follows implantation of streptococci upon previously damaged heart valves; the micro-organisms originate in a distant focus, and are carried by the bloodstream. Tuberculosis of the kidney is usually secondary to pulmonary tuberculosis, while gonorrheal endocarditis results from gonorrheal urethritis as the primary focus.

Destruction of bacteria.—Many physical and chemical agents exert a destructive influence upon bacteria, and are widely utilized in the control and prevention of infection.

The environmental temperature largely determines the rate of bacterial growth. Each species has its own optimum temperature, and an upper and lower limit which is compatible with existence. Bacteria inimical to the human organism grow best at body temperature.

Contrary to popular belief, boiling temperature is not needed to destroy bacterial life if sufficiently long exposure is given at lower temperatures. After 10 minutes' exposure in a moist medium, many pathogenic bacteria including the tubercle bacillus are destroyed at 60° C. or 140° F. Thus pasteurization, which maintains the temperature of milk at 140° F. for 20 minutes, insures destruction of all pathogenic bacteria (except spores).

Spores are hardier than the vegetative forms and at times resist a temperature of 100° C. For complete destruction of all bacterial life, a temperature of 125° C., under steam pressure, maintained for 15 minutes, is required.

Moisture is essential for bacterial growth; drying is detrimental. Many bacteria, such as the gonococcus and the spirochete of syphilis, are rapidly killed by drying. Other pathogenic bacteria are destroyed by several hours' drying. The tubercle bacillus is a notorious exception and remains alive for long periods in the absence of moisture.

Bacteria may be destroyed by chemical agents. Many substances have been introduced for this purpose. In this connection it is necessary to distinguish between inhibition of bacterial growth (bacteriostasis) and complete destruction of bacterial life (germicidal activity.) Many agents are bacteriostatic in high dilution, but must be in higher concentration to be germicidal.

The most commonly employed germicides are tincture of iodine, bichloride of mercury solution (1:1000), phenol (5%), and 70% ethyl alcohol. Bichloride of mercury combines with organic matter, hence should

not be used in the presence of pus, which quickly lowers its germicidal power.

Procedures in surgical and medical asepsis.—In surgical aseptic technique, the operative field is rendered sterile, and all objects coming into contact with it are previously made bacteria-free. Thus no bacteria are permitted to enter the wound, and usually no infection follows. Air-borne bacteria cannot be controlled, and occasionally appear to be responsible for postoperative suppuration. Infection from virulent streptococci harbored in the throats of operating room personnel is believed possible by some surgeons; transmission is thought to occur via the expired air.

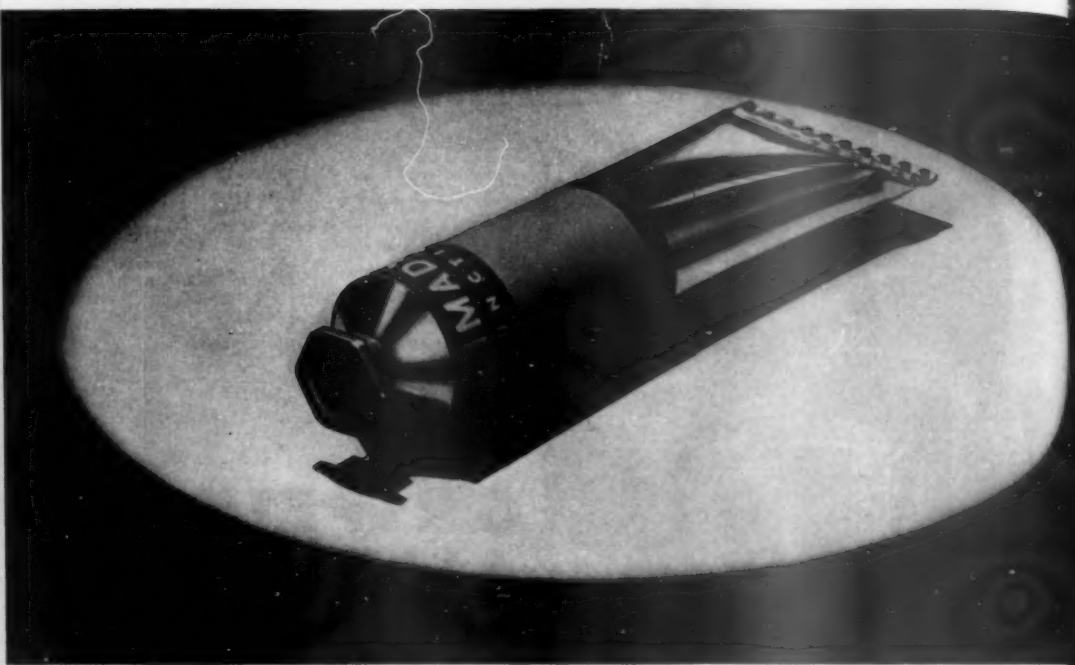
In medical asepsis, referring particularly to infectious or communicable diseases, the limits of the contaminated space are outlined. Every effort is made to prevent spread beyond the confines of these limits, in order to protect the attending nurse and other patients in the same ward or on the same floor. The nurse, upon entering the room, puts on a gown to prevent contamination of her uniform. Before leaving, the hands are thoroughly sterilized, and the gown is carefully removed. Thus the pathogenic micro-organisms are not transported from contaminated to noncontaminated areas. After the patient is discharged, all linen is thoroughly sterilized, and all other equipment is disinfected by the most convenient and effective methods. [*Send a stamped addressed envelope for a bibliography on the procedures discussed in this article.*—THE EDITORS.]

Nutrition briefs

[*Continued from page* 17]

to prolonged overnutrition. Treatment consisted of a daily diet of approximately 600 calories. For a short time thyroid extract was given to counteract the decline of the metabolic rate resulting from a prolonged submaintenance diet.

This case indicates that there is no limit in the extent to which weight may be reduced by low caloric diets, provided such diets contain adequate protein, minerals and vitamins, plus moderate amounts of carbohydrates and a minimal amount of fat. Vitamins are often added in concentrated form. Skim milk and cottage cheese are important in providing enough calcium and phosphorus. —*Short, J. J.: Extreme Obesity Followed by Therapeutic Reduction, J. Amer. Med. Ass'n., Dec. 10, 1938.*



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CIGARETTES: Science reports that the influence of tobacco is measured by its nicotine content. But, does nicotine alter the flavor of a good cigarette? The makers of SANO denicotinized cigarettes invite you to make a personal test without cost. Nurses writing in before April 10 will be sent samples of the product and descriptive literature. Health Cigar Co., Dept. RN 3-39, 154 West 14th St., New York, N.Y.

COFFEE: Suppose you're devoted to coffee but the doctor says "no caffein." Well, even the darkest cloud has a silver lining. According to the Council on Foods of the A.M.A., SANKA coffee is free from caffein effect and "can be used when other coffee has been forbidden." Write for generous trial portion. General Foods, Dept. RN 3-39, Battle Creek, Mich.

POPLIN: A uniform that will survive hard wear and constant laundering—that's what every nurse wants. NURSES FRIEND POPLIN, incorporating a new technique of yarn balance in weaving, promises to fill the bill. Abrasion tests on the fabric report three times as much durability as that of ordinary poplin, and with no sacrifice in beauty. Ask your dealer to show you some uniforms made up in this fabric. A swatch of the material will be sent you on request. Stone Mill Fabrics Corp., Dept. RN 3-39, 40 Worth St., New York, N.Y.

LAXATIVE: The first requirement of a good laxative is that it be *effective*. But a laxative should be gentle, too, and pleasant to take. Ex-LAX is said to check on all three points. Its action is described as thorough, yet free from the strain, discomfort, and weakening after-effects so often produced by strong cathartics and purgatives. Tastes just like delicious chocolate. Address request for a sample to Ex-Lax, Inc., Dept. RN 3-39, 423 Atlantic Ave., Brooklyn, N.Y.

CHEWING GUM: The soft, easy-to-chew foods of modern diet deprive teeth, gums, and jaws of strengthening exercise. Hence, a number of dentists suggest juvenile gum in the treatment of oral disorders where massage and exercise are needed. The benefits of this type of exercise are presented in an interesting pamphlet, *Chew Your Way to Better Oral Health*. For your copy, write Frank H. Fleer Corp., Dept. RN 3-39, 10th and Diamond Sts. Philadelphia, Pa.

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UNIFORMS: With spring just around the corner, it's time to order new uniforms. If you have gone a little "rusty" on professional styles, UNIFORMS OF TOMORROW may help you. A new catalogue, it emphasizes new lines, new weaves, and improved materials. For your copy, address Jacobs Bros., Dept. RN 3-39, 1350 Broadway, New York, N.Y.

Classified

There is no charge to registered nurses for the use of this department. To apply for a "position available," simply outline your qualifications in a letter. Address the letter to the correct box number care of R.N.—A JOURNAL FOR NURSES, *Rutherford, N. J. (Send no money with your application. If the bureau requires a registration fee, it will bill you separately.) Submit "positions wanted" early. They will be published in the order received.*

POSITIONS AVAILABLE

DOCTOR'S ASSISTANT: Southwestern Minnesota, vicinity Osceola County, Iowa. Physician-surgeon needs registered nurse with laboratory training. Salary, with maintenance, $60 up. Address application to Dr. P. J. Cress, Ellsworth, Minn.

***GENERAL DUTY:** Eastern state. General duty nurses for 400-bed eastern hospital affiliated with university. Salary $65-75, depending on experience and training. (Placement bureau charges $2 registration fee.) C741.

***NIGHT NURSE:** Illinois. For 115-bed tuberculosis sanatorium. Hours 9 P.M. to 7 A.M. Excellent living conditions. Salary, including maintenance, $75. (Placement bureau charges $2 registration fee.) C733.

***SUPERVISOR:** Iowa. Must assume complete charge operating room and obstetrical departments scrubbing for all surgical and obstetrical cases. Private general hospital in college town. Graduate staffed, 55 beds. Salary $90, maintenance. (Placement bureau charges $2 registration fee.) C736.

***SUPERVISOR:** Middlewest. Assistant supervisor of nurses for health department in large city. Preparation in public health nursing specified. Salary commensurate with experience. (Placement bureau charges $2 registration fee.) C731.

***SUPERVISOR:** Nebraska. Operating room. Postgraduate training necessary. General 100-bed hospital with training school. Salary to start $90, maintenance included. Excellent opportunity for advancement. (Placement bureau charges $2 registration fee.) C737.

***SUPERVISOR:** New York. Night supervisor willing to combine supervision and general duty nursing. Private general hospital with 55 beds, graduate staff. Salary $90 and full maintenance. (Placement bureau charges $2 registration fee.) C735.

***SUPERVISOR:** Wisconsin. Night obstetrical supervisor to take charge of department including delivery room and nursery. Postgraduate work required. General hospital with 150 beds, training school. Salary $100. (Placement bureau charges $2 registration fee.) C734.

***SUPERINTENDENT:** Iowa. Private 50-bed general hospital needs capable nurse superintendent. All-graduate staff. Salary according to experience. (Placement bureau charges $2 registration fee.) C739.

***SUPERINTENDENT OF NURSES:** Pennsylvania. Well located 100-bed general hospital with accredited training school. Salary $150, maintenance. (Placement bureau charges $2 registration fee.) C740.

***SURGICAL NURSE:** Kentucky. Post in 50-bed industrial hospital. Applicant should have postgraduate training. Salary $109 and maintenance. (Placement bureau charges $2 registration fee.) C738.

POSITIONS WANTED

ANESTHETIST: Available April. Experienced in administering ether, chloroform, avertin, nitrous and ethylene gas. Prefers hospital in southern state. Box 3-1.

GENERAL DUTY: Nebraska registered nurse desires day duty in Oregon. Graduate of 300-bed hospital; 9 years' experience general and private duty. Age 30. Salary open. Box 3-2.

INDUSTRIAL: Or office position. Experienced 5 years private and institutional duty, especially accident room. Certified for advanced first-aid course. Also doctor's office experience and two years' bookkeeping. Age 28. Drives own car. Pennsylvania registration. No locality preference. Fine references. Salary open. Box 3-5.

MALE NURSE: Broad experience including psychiatric and industrial nursing. Desires to locate in Massachusetts hospital. Rhode Island registration. Minimum salary $90, including maintenance. Box 3-6.

NURSE-SECRETARY: Employed 7 years in eye, ear, nose and throat specialist's office. Capable, alert, trustworthy. Would like position in Connecticut or New York State. Box 3-7.

OBSTETRICAL NURSE: Desires post in delivery room, or as floor supervisor. Postgraduate train-

**Asterisk indicates position listed by a placement bureau.*

ing in obstetrics Philadelphia Lying In Hospital. Registered in Pennsylvania, Maryland, and District of Columbia. Box 3-8.

OFFICE NURSE: Age 24. New Jersey and Pennsylvania registration. Seeks position in clinic or doctor's office, vicinity Trenton or Philadelphia. Secretarial experience. Protestant. Good references. Box 3-9.

PUBLIC HEALTH: Also interested in clinic (social hygiene), industrial, or institutional nursing. Experience includes obstetrical, ear, nose, and throat, first aid, visiting nursing, social hygiene nursing. Medical Centre (N. J.) graduate; some college training. Single. Age 25. Prefers Los Angeles location. Available March 15th. Box 3-10.

SCHOOL NURSE: Registered in Pennsylvania. Four years as resident school nurse; 6 seasons as camp nurse. Seeks opening in school, industrial dispensary, or doctor's office. Age 40. Protestant. Box 3-11.

SUPERVISOR: Will consider general duty. Age 35. Protestant. In institutional and private duty 14 years. Postgraduate work in surgery and obstetrics. Registered in Illinois. Excellent references. South or Southwest preferred. Salary open. Box 3-12.

SUPERINTENDENT: Also consider supervisor opening. Experienced in psychiatry and tuberculosis. Excellent references and credentials. Will locate anywhere but prefers West. Box 3-14.

SURGICAL: Seeks position in foreign country. Ten years' experience in operating room; past 1½ years in charge of surgery tuberculosis sanatorium. Registered in New Jersey. Age 37. Box 3-17.

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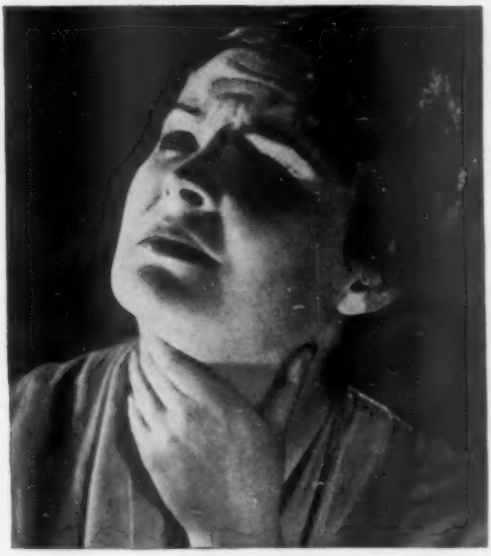

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*Nutrition Studies Following Tonsillectomies. J. S. Stovin, *Medical Record*, 149:63, 1939.

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